



DETERMINATION OF MEDICAID DISABILITY SOCIAL SUMMARY

State Form 1111 (R8 / 6-04) / OMPP 0251B

ALL 8 SECTIONS MUST BE COMPLETED.

CONFIDENTIALITY STATEMENT

The personal information requested on this form will be used in the determination of the applicant's entitlement to or continued receipt of Medical Assistance administered by the Office of Medicaid Policy and Planning. Disclosure by the applicant of the information requested is mandatory pursuant to the provisions of I.C. 12-15 et seq. Non-disclosure of the information requested will hamper and possibly prevent the delivery of assistance to the applicant. All personal information collected on this form will be treated as confidential pursuant to 470 IAC 1-2-7 and 470 IAC 1-3-1.

SECTION 1. IDENTIFYING INFORMATION

Name of applicant	Social Security number	
Case number	Date of birth (month, day, year)	Application date (month, day, year)

SECTION 2. SOCIAL SECURITY INFORMATION

Has the applicant applied for:

- (a) Social Security Disability benefits? ☐ Yes ☐ No
(b) Supplemental Security Income (SSI) benefits? ☐ Yes ☐ No

If yes to (a) or (b) above, what is the status of the request?

Effective date of denial: _____

Effective date of approval: _____

Application is pending: _____

(c) Does the applicant receive Retirement Survivor's Disability Insurance (RSDI) based on disability? ☐ Yes ☐ No

SECTION 3. LIVING ARRANGEMENTS (Check One)

Applicant lives:

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Alone | <input type="checkbox"/> With other relative | <input type="checkbox"/> Nursing Home |
| <input type="checkbox"/> With spouse | <input type="checkbox"/> With non-relative | <input type="checkbox"/> Group Home |
| <input type="checkbox"/> With parent | <input type="checkbox"/> County Home | <input type="checkbox"/> State Facility |
| | <input type="checkbox"/> Halfway House | <input type="checkbox"/> Homeless / Shelter |

SECTION 4. MEDICAL HISTORY

(A) Applicant has the following physical and / or mental disability

DISABILITY	DATE DISABILITY BEGAN

(B) Is the applicant currently under a doctor's care?

☐ Yes ☐ No

If yes, name of doctor

Address (number and street, city, state, ZIP code)

Telephone number

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SECTION 4. MEDICAL HISTORY (continued)

(C) Has the applicant received a physical exam in the past 3 months?

☐ Yes ☐ No

If yes, name of doctor

Address (*number and street, city, state, ZIP code*)

Telephone number

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(D) Medical and psychological treatment history within the past 12 months: (****Fill in or write the word "NONE." This table cannot be left blank!****)

FULL NAME AND ADDRESS OF DOCTOR, PSYCHIATRIST, HOSPITAL, CLINIC, INSTITUTION, MENTAL HEALTH AGENCY OR OTHER	DATE(S) OF MOST RECENT CARE	REASON FOR VISIT

(E) Applicant is taking the following **medications** (*correct spelling and dosage is important*) / **treatments** / **therapies**:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

SECTION 5. FUNCTIONAL LIMITATIONS

Applicant states the disability limits performance in the following areas (*examples: lifting, walking, bending, sitting, driving, etc.*)

Applicant uses the following devices for walking / moving around: (*check all that apply*)

☐ Cane ☐ Walker ☐ Crutches ☐ Wheelchair ☐ Braces (*what type*): _____

SECTION 6. EDUCATION

Highest grade completed: _____

(a) High School Diploma received: ☐ Yes ☐ No

Date: _____

(b) GED received: ☐ Yes ☐ No

Date: _____

Attended College: ☐ Yes ☐ No

Date: _____

Attended Technical School: ☐ Yes ☐ No

Date: _____

Received Special Education: ☐ Yes ☐ No

Date: _____

SECTION 6. EDUCATION (Continued)

LIST MAJOR AREAS OF STUDY OR TRAINING COMPLETED		DATE COMPLETED
Is applicant able to read? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is applicant able to write? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is applicant able to speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 7. EMPLOYMENT AND VOCATIONAL REHABILITATION

Is applicant currently working? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, complete the following:		
(a) Number of hours worked per week	If not full-time, why? <input type="checkbox"/> Disability limits hours can work, or <input type="checkbox"/> More work hours are not available	
(b) Present employer is:		
The job being done is:		
(c) Earns \$ _____ per hour or \$ _____ per week.		
(d) Are there any special working conditions based solely upon disability? If yes, describe: ----- -----		
If applicant is not currently working but has worked in the past, what is the title of the job performed:		Date last worked:
Please <u>check one</u> of the following regarding the applicant's work history: <input type="checkbox"/> Manual labor only <input type="checkbox"/> Clerical or Sedentary <input type="checkbox"/> Sheltered Workshop <input type="checkbox"/> Job Coach <input type="checkbox"/> Unable to Keep Jobs <input type="checkbox"/> Never Employed		
Vocational Rehabilitation:		
Is the applicant currently receiving vocational rehabilitation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has the applicant received vocational rehabilitation in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when?

SECTION 8. CASEWORKER'S SUMMARY (*Very important to complete.*)

(a) **Appearance:** *(Describe what you see.)*

SECTION 8. CASEWORKER'S SUMMARY (Very important to complete.) (Continued)

(b) **Medical:** (Describe what you see and hear relating to the applicant's disability.)

(c) **Psychological:** (Describe what you notice during the interview - does the applicant see things that aren't there? Hear voices? Talk about suicide? Use drugs or alcohol? Have a history of psychological problems?)

(d) **Social:** (Describe how the applicant behaves during the interview. Is (s)he able to understand your questions? Able to communicate with you in an understandable manner? Is another person assisting the applicant with the interview?)

(e) **Other:** (For comments on anything that doesn't fit in the above areas.)

Who completed this form?

☐ Caseworker ☐ Other (explain relationship to applicant) _____

How was interview conducted?

☐ In person ☐ By telephone ☐ Application was taken by a professional service